

sensitive to pressure—was laid bare. No changes were found in this vessel or its neighborhood. It was ligated with a simple ligature in the middle of the neck. Succeeding this the wall of the sigmoid fossa was so far removed as to permit exposure of the sinus from the so-called knee downward for 2½ cm. After incision of the thickened pus-covered sinus-wall, free pus escaped from the interior of the sinus, and the rest of the purulent contents was carefully mopped away. No firm occlusion, either by peripheral or central thrombus, was found. A little bleeding occurred from the peripheral end of the severed sinus, but this was checked easily with a tampon. The case now proceeded most favorably; there were no more pain, no chills, and on October 26th the patient was permitted to leave the hospital.

As the author states, this case shows the advantage of operating in sinus-thrombosis while the thrombus is confined to the mastoid portion of the sinus.

An Acute Syphilitic Affection of the Ear.—E. A. CROCKETT describes an acute syphilitic affection of the ear, probably of the internal ear (*Boston Medical and Surgical Journal*, February 11, 1897). This affection consists in very sudden and severe deafness, more or less severe vertigo, and violent tinnitus occurring in persons previously free from ear-disease, but who have had syphilis not long before the ear-symptoms showed themselves. "This complex of symptoms should always suggest syphilis, and will be found to be caused by it in the large majority of cases where there has been no previous ear-trouble. We do not meet the same group in the rare cases of labyrinthine hemorrhage or tumor, and also in the rare and sudden fixations of the stapes which occur in the deep middle-ear thickenings. In these cases the history and hearing-tests, or, in case these fail, the treatment will immediately show us the probable cause." In the syphilitic cases the watch-and-voice-deafness is marked, and the tuning-fork of middle register is wholly lost to bone-conduction, but remains "fair for air-conduction." "The acute labyrinthine processes, on the other hand, show a marked loss of high tones in all cases, and in the more severe ones a total deafness by both air- and bone-conduction over a greater part of the region." The pathological process in these cases is not well understood. The clinical evidence would seem to be in favor of an effusion into the labyrinth as a cause of the particular group of symptoms we are considering. The early tertiary or late secondary period seems to be the favorite time for this particular lesion. Close examination will reveal the fact that only the auditory nerve is affected, which should aid in the differential diagnosis. The administration of mercury and iodide of potassium to the maximum limit will often be of no avail. "Here the subcutaneous administration of pilocarpine up to its full physiological limit will be of great service. The improvement in hearing and the diminution of vertigo following the administration of this drug is in acute cases little short of marvellous."

Labyrinthine Vertigo.—GELLÉ points out that labyrinthine vertigo depends upon a number of causes (*La Tribune médicale*, July 16, 1896; also *Therapeutic Gazette*, December 16, 1896). When it is due to anæmia of the labyrinth the symptoms are vertigo, subjective noises in the ears, and a tendency to syncope. It is sometimes seen in persons who have suffered

from chronic diarrhoea or other diseases impairing the general nutrition, and in cases of prolonged lactation or of convalescence from grave diseases; in cases of marked albuminuria, in cachectic affections, in dilatation of the heart, and similar disorders. Arteriosclerosis, senility, diabetes, and bleeding hemorrhoids may also provoke it. It is sometimes due to local thickening of the tympanic tissues, particularly of the membrana tympani. In many of these cases there are associated with the vertigo hyperæsthesia and pain. The remedies recommended are the glycerophosphates and a tonic regimen, the use of stimulants, the employment of milk and iodides if arteriosclerosis or cardiac disease is present. The use of the milk-diet, with a few drops of the tincture of strophanthus, or small doses of sparteine or caffeine, alternated with fluid extract of kola, has proved valuable. Should syphilis be the cause, of course antisyphilitic remedies must be employed. Should the vertigo be associated with middle-ear disease, local treatment of the ear becomes of the greatest importance. Here bromides, strychnine, and arsenic become of value. Gellé believes that sulphate of quinine is a valuable aid in many cases of persistent vertigo following primary or secondary disease of the internal ear. *Many cases, however, are best relieved of their vertigo by surgical interference with the bones of the ear.*

In ear-vertigo associated with toothache and neuralgia of the fifth pair of nerves sulphate of quinine is also useful and may be associated with small doses of aconite. Vertigo due to toxæmia of any kind must be treated by combating the peculiar poison producing it: malaria, gout, constipation, tobacco, salicylate of sodium, and excess of quinine may cause vertigo, and must be guarded against, therefore. Vertigo may be due to reflex causes, and this form is seen most frequently in hysterical and neurasthenic persons, and is frequently associated with migraine or facial neuralgia, never with hepatic or nephritic colic.

Gellé's conclusion is that in labyrinthine vertigo sulphate of quinine is of extraordinary importance, and that it is useful in the majority of instances.

Pyæmia after Acute Suppuration of the Middle Ear.—RÖPKE (*Archives of Otolaryngology*, vol. xxv. No. 4) reports a case of well-marked pyæmia fully established in the third week of the aural disease. The secondary infection in this case was evidently due to the improper treatment of the ear (the left) in the acute stage of inflammation by syringing with chamomile-tea and poulticing, as ordered by the family physician. The local mastoid symptoms were largely negative. There was nearly constant pain in the left temple. The eye-ground was not examined. Chills, rapid rise and fall of temperature, the permanently rapid pulse, even in intervals of normal temperature, tumor of the spleen, and the dry, cracked, thickly coated tongue were relied upon in establishing the diagnosis of otitic pyæmia from osteophlebitis. Suppuration of the mastoid cells and probably acute necrosis of the bone-tissue of this cavity were evidenced by the profuse discharge from the ear and the tenderness of the mastoid to pressure. No external symptoms of sinus-phlebitis were present. There was no œdema either in the region of the temple or at the posterior boundary of the mastoid.

The mastoid cavity and antrum were opened, found full of pus and granulations, and then completely cleared out. The vertical portion of the lateral